Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ALL-STAR CHIROPRACTIC & REHAB
8208 BEDFORD EULESS ROAD
N. RICHLAND HILLS TX 76180

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
AMERICAN HOME ASSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-05-1489-01

MFDR Date Received
OCTOBER 27, 2004

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This letter is in reference to a Medical Dispute we are filing against AIG Claims. Nancy Lopez had won her CCH on June 25, 2004 and the carrier (AIG Claims) was ordered to pay. Her compensable injury was found to be bilateral wrist flexor tendonitis, not carpal tunnel. We were treating both 727.05 and 954.0. Before I resubmitted I called Syan who is the adjuster and he stating if the diagnosis code was on the HCFA 354.0 they would not pay, so I took it off the HCFA's but not on the notes. I had resubmitted all claims requesting for reconsideration on July 9, 2004 along with all the notes, EOB's and the HCFA's. We have received only a few payments from my resubmission. I have never received any other EOB's from my resubmission on July 9th. I have called the adjuster on 9-7-04 Syan to find out why these were not paid yet and he stated he would find our and call me back. Syan never returned my call, so I called AIG and spoke with Sharon in Customer Service who stated that they are still showing they are denied and that the adjuster needs to reset the order. Syan stated that he had done this already and is not sure why they are stating this. I feel we are getting the run around. I am attaching 2 copies of HCFA's stamped request for reconsideration along with the 1st denials, and the letter requesting reconsideration on July 9th. I have also attached the orders from her CCH, one copy goes to TWCC and the other to the insurance carrier…"

Amount in Dispute: $16,053.33*

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This dispute involves DOS 10/21/03 through 05/25/04. The Claimant's injure was determined to include on bilateral wrist flexor tendonitis by CCH. Carrier has denied all bills according to the Requestor. Carrier would first note that it paid DOS 12/03/03, CPT Codes 97035 and 9712459 ($14.93 & $27.14 respectively) and DOS 12/05/03, CPT Codes 98943, 97110, 97032, 97035, 9712459 ($35.10, $137.36, $19.89, $14.03 & $27.14 respectively). **Exhibit A.** Second, the provider failed to properly document that the billed services were for the compensable injury and thus the carrier cannot reprocess the bills properly…"

Response Submitted by: Flahive, Ogden & Latson, PO Drawer 13367, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 20, 2003, May 20, 2005 through June 30, 2005	Physical Therapy – Dates submitted on updated Table were not on original Table of Disputed Services	$1,948.00	$0.00
October 27, 2003 through November 14, 2003; November 19, 2003 through January 14, 2004; January 21, 2004 through January 23, 2004; January 28, 2004 through February 2, 2004; April 21, 2004; April 30, 2004;	Physical Therapy – Dates of service that have been paid or not listed on updated table.	$7,641.72	$0.00
November 17, 2003; January 16, 2004; January 19, 2004; January 26, 2004, February 4, 2004 through February 27, 2004; March 1, 2004 through March 22, 2004; April 14, 2004 through April 28, 2004; May 14, 2004 and May 25, 2004	Physical Therapy – Dates of service that have not been paid CPT Codes 98943, 97110, 97032, 97035, 97124-59, 99080-73, 97018	$8,696.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.300 sets out the procedures for insurance carrier receipt of medical bills from the health care provider.
3. 28 Texas Administrative Code §133.304 sets out the procedures for medical payments and denials.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated December 30, 2003 through June 18, 2004 and January 25, 2005 through March 24, 2005.
   - E, 1 – Entitlement (non-compensable). (X962)
   - 1, Claim is being disputed, therefore no payment is being made at this time. (X727)
   - 1 – The service(s) is for a condition(s) which is not related to the covered work related injury. (X347)
   - 3 – This charge has been reimbursed according to the appropriate fee schedule or usual and customary value. (Z651)
   - 3 – This item was previously submitted and reviewed with notification of decision issued to payor/provider (duplicate invoice). (ZU301)

Findings

1. The insurance carrier denied the injury as non-compensable. A benefit review conference was held on April 20, 2004 to mediate resolution of the disputed issues, but the parties were unable to reach agreement. A benefit contested care hearing was held on June 24, 2004 to decide the following disputed issue: 1. Does the August 25, 2003 compensable injury extend to include the bilateral carpal tunnel syndrome in addition to bilateral wrist flexor tendonitis? The decision and order of the Hearing Officer dated June 25, 2004 states that the claimant's August 25, 2003 compensable injury extends to include bilateral wrist flexor tendonitis, but not carpal tunnel syndrome. The Hearing Officer has also ordered the carrier to pay benefits in accordance with his decision, the Texas Workers' Compensation Act and the Commissioner's Rules.

2. In accordance with 28 Texas Administrative Code §133.307(d) “A person or entity who fails to timely file a request waives the right to medical dispute resolution. The commission shall deem a request to be filed on the date the division receives the request, and timeliness shall be determined as follows: (1) A request for medical dispute resolution on a carrier denial or reduction of a medical bill pursuant to §133.304 of this title (relating to Medical Payments and Denials) or an employee reimbursement request shall be considered timely if it is filed with the division no later than one (1) year after the date(s) of service in dispute.” Review of the submitted updated table concludes that the requestor has met the requirements of 28 Texas Administrative Code §133.307(d)(1).
3. On January 14, 2013 the Division requested an updated table from the requestor. On January 17, 2013, the requestor submitted an updated table listing the dates of service and total amounts for each date of service still remaining unpaid; however, it significantly changed the amount in dispute. The requestor also added several dates of service, as noted in the above table, that were not listed on the original request for medical dispute resolution. These dates of service will not be reviewed as they were not on the original table.
4. According to the requestor’s position summary, All-Star Chiropractic and Rehab was treating both 727.95 – Wrist Tenosynovitis and 354.0 – Carpal Tunnel Syndrome prior to the benefit contest case hearing. However, the respondent submitted bills from the requestor, dated October 1, 2003 through May 28, 2004, that lists 354.00 – CTS as the only diagnosis code used for treatment of the injured employee. Furthermore, the requestor states in their request for reconsideration, dated July 9, 2004, “Enclosed are all the HCFA’s, notes and EOB’s. If you notice on the HCFA’s the diagnosis are Bilateral Wrist Flexor Tendonitis and CT.” The bills submitted with the request for medical dispute resolution do not contain the diagnosis code 354.0, carpal tunnel syndrome, as stated in the position summary. According to 28 Texas Administrative Code §133.304(k)(1)(A-B) and (2-3) states: "If the sender of the bill is dissatisfied with the insurance carrier's final action on a medical bill, the sender may request that the insurance carrier reconsider its action. The sender shall submit the request for reconsideration by facsimile or mutually agreed upon electronic transmission unless the request cannot be sent by those media, in which case the sender shall send the request by mail or personal delivery; the request shall include: (1) a copy of the complete medical bill that the health care provider is requesting the insurance carrier to reconsider, (A) clearly marked with the statement "REQUEST FOR RECONSIDERATION" (B) with the identical codes and charges that are on the original medical bill; (2) a copy of the explanation of benefits; and (3) a claim-specific substantive explanation that enables the insurance carrier to understand the sender's position. This explanation shall rebut the insurance carrier's reason for its action as indicated on the explanation of benefits. A generic statement that simply states a conclusion such as "insurance carrier improperly reduced the bill" or other similar phrases with no further description of the factual basis for the sender's position does not satisfy the requirements of this section." Review of the submitted bills shows the bills are not copies of the original bills, as submitted by the respondent, although they are stamped with “request for reconsideration” they are not the same bills as submitted by the respondent.
5. Bills submitted by the requestor for dates of service January 16, 2004 through May 25, 2004 are also stamped with “CORRECTED BILLING”. In accordance with 28 Texas Administrative Code §133.300(e), which states in part, “The sender may correct the incomplete bill and resubmit it to the insurance carrier as a new bill.” The requestor submitted corrected bills and a request for reconsideration should have been made for the new bills in accordance with 28 Texas Administrative Code §133.304(k)(1)(A-B), (2) and (3). Review of the documentation submitted by the requestor does not support a request for reconsideration was made on the corrected bills.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 28, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.